MDR Tracking Number: M5-04-2589-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 4-16-04.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

The Level III and IV established patient office visit, neuromuscular reeducation, massage therapy, electrical stimulation unattended, hot/cold pack therapy, myofascial release, therapeutic exercises, therapeutic activities, and manual therapy technique from 5-14-03 through 6-16-03 were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were not the only fees involved in the medical dispute to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 7-2-04 the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

- Regarding CPT Code 99213 for dates of service 6-21-03 and 6-27-03: In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service. Therefore, **reimbursement is recommended in the amount of $96.00** in accordance with the 1996 Medical Fee Guidelines.

- Regarding CPT Code 97140 for dates of service 6-21-03 and 6-27-03: This is not a valid CPT Code in the 1996 Medical Fee Guidelines. **No reimbursement is recommended.**

- Regarding CPT Code 97530 for dates of service 6-21-03 and 6-27-03: In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service. Therefore**, reimbursement is recommended in the amount of $210.00** in accordance with the 1996 Medical Fee Guidelines.

- Regarding CPT Code 97110 for dates of service 6-21-03 and 6-27-03: Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate

overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. **Reimbursement not recommended.**

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service 5-14-03 through 6-27-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Decision and Order is hereby issued this 19th day of October, 2004.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

DA/da

June 29, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-2589-01
TWCC #:
Injured Employee:
Requestor:
Respondent:
------ Case #:

------ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ------ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ------ for independent review in accordance with this Rule.

------ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided

by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ------ external review panel who is familiar with the with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ------ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ------ for independent review. In addition, the ------ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a female who sustained a work related injury on ------. The patient reported that while at work she injured her neck, right shoulder and back when a marble object fell on her. A MRI of the right shoulder performed on 1/3/03 indicated a type II-III acromion process associated with mild capsular hypertrophy of the AC joint and effacement of the subacromial fat pad. A MRI of the lumbar spine performed on the same date showed dessication of the discs at L1-2 and L4-5, a 4mm broad based disc protrusion/extrusion at L4-5, a 2-3 broad based disc protrusion at L3-4, a 1mm bulge of the annulus at L1-2, and facet arthrosis of the mid to lower lumbar spine. On 5/14/03 the patient underwent right shoulder injection. A reevaluation of the patient performed on 5/14/03 indicated that the diagnoses for this patient have included other affections of shoulder region, not elsewhere classified, displacement of lumbar intervertebral disc without myelopathy, rotator cuff syndrome of shoulder and allied disorders, and myofasciitis. Treatment for this patient's condition has included heat therapy, electro-muscle stimulation, therapeutic massage, neuromuscular reeducation, myofascial release, kinetic mobilization therapy, and therapeutic exercises.

Requested Services

Level III & UV established patient office visit, neuromuscular reeducation, massage therapy, electrical stimulation unattended, hot/cold pack therapy, myofascial release, therapeutic exercises, therpautic activities, and manual therapy technique from 5/14/03 through 6/16/03.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Initial Exam 10/30/02
2. MRI reports 1/3/03
3. Injection note 5/14/03
4. Office notes 5/21/03 – 6/21/03
5. Reevaluation note 5/14/03

Documents Submitted by Respondent:

1. No documents submitted

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is overturned.

Rationale/Basis for Decision

The ------ chiropractor reviewer noted that this case concerns a female who sustained a work related injury to her right shoulder and back on -------. The ------ chiropractor reviewer also noted that the diagnoses for this patient have included other affections of shoulder region, not elsewhere classified, displacement of lumbar intervertebral disc without myelopathy, rotator cuff syndrome of shoulder and allied disorders, and myofasciitis. The ------ physician reviewer further noted that treatment for this patient's condition has included heat therapy, electro-muscle stimulation, therapeutic massage, neuromuscular reeducation, myofascial release, kinetic mobilization therapy, therapeutic exercises and an injection of the right shoulder on 5/14/03. The ------ chiropractor reviewer indicated that the patient went through several aggressive treatments. The ------ chiropractor reviewer noted that after the patient had improved 25% with conservative care, the patient underwent an injection on 5/14/03. The ------ chiropractor reviewer indicated that postoperative therapy was recommended. The ------ chiropractor reviewer explained that the patient underwent 12 sessions of therapy over a 4-week period. The ------ chiropractor reviewer indicated that 12 sessions of therapy over a 4-wek period is acceptable and medically necessary treatment. The ------ chiropractor reviewer explained that the patient had not been deemed at maximum medical improvement until 4/12/04.

Therefore, the ------ chiropractor consultant concluded that the Level III & UV established patient office visit, neuromuscular reeducation, massage therapy, electrical stimulation unattended, hot/cold pack therapy, myofascial release, therapeutic exercises, therpautic activities, and manual therapy technique from 5/14/03 through 6/16/03 were medically necessary to treat this patient's condition.

Sincerely,